Boca Integrative Health, PA

A Group of Independent Professional Associations
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QUICK FORM FOR NUTRITIONAL ASSESSMENT

Name: _____ Date: _____

Email: _____

Circle 1 to 5: Being 5 as severe or very often.

Are you under stress?	1	2	3	4	5
Do you lack in energy?	1	2	3	4	5
Do you get headaches?	1	2	3	4	5
Do you sleep poorly?	1	2	3	4	5
Do you have food cravings?	1	2	3	4	5
Do you have poor eating habits?	1	2	3	4	5
Do you exercise too little or too much?	1	2	3	4	5

Answer Y for YES or N for No.

Do you have Diabetes?	Y	N
Do you have high cholesterol?	Y	N
Do you drink more than 3 cups of coffee/day?	Y	N
Do you smoke cigarettes?	Y	N
Do you eat less than 4 vegetables/day?	Y	N
Do you eat less than 2 fruits/day?	Y	N
Do you eat out more than 14 meals/week? (Being there is 21/week)	Y	N